Funding Services

Funding for the cost of home modifications, technology, or services needed by consumers who experience a disability are provided by numerous programs. The guidelines and eligibility requirements of these programs vary widely and are often overlooked as potential resources for those who are unfamiliar with how to access them.

The Assistive Technology Partnership's Resource Specialist will research the various programs across the state to determine a persons potential eligibility for funding assistance.

The Process

1. Complete the attached application form. It is used to gather information about the services and/or devices needed.

   This form is fillable for print purposes only. This form can be completed and printed; however, this form cannot be submitted electronically and any information you add to this form cannot be saved.

2. **Return the completed and signed form to: Assistive Technology Partnership, 3901 N. 27th Street, Suite 5, Lincoln, NE, 68521**
3. The Resource Specialist will use the application information to identify the program(s) that are potential resources to cover or supplement the cost of the technology or services needed by the applicant.
4. The applicant will be notified of eligibility, and any necessary referrals will be made to the appropriate specialist, program or service. **This process takes about two weeks, but in some instances it may take longer.**

Please Note: Since funding is limited, eligibility does not always guarantee that funds will be available. If necessary, a waiting list will be maintained to serve consumers as funding availability allows.

For more information on funding, call the

Assistive Technology Partnership (toll free) 888.806.6287.

Service & Device Application (Multi-Agency Form)

Date _____

Applicant/Person with Disability

Name (first, middle, last)

_____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Address

City/State/Zip Code

County

Home Phone

Work Phone

E-mail

Date of birth

Social Security Number

What is your disability?

How does your disability impact your daily living activities?

Assisting with this form, i.e. Parent/Guardian/Representative

Name

Relationship to applicant

Address

City/State/Zip Code

Phone

E-mail

Referral Source

Name

Agency/Organization

Address

City/State/Zip Code

Phone

E-mail

Case Manager or Services Coordinator

• Name

Agency/Organization

Phone

• Name

Agency/Organization

Phone

Household Members

Name	**Relationship to applicant** (e.g. spouse, son, daughter, attendant, guardian, etc.)	**Date of birth**

List the services and devices you are requesting. List the most important <u>first</u>.	**Estimated cost (if known)**
1. _____	
2. _____	
3. _____	

• **Services and Devices Requested**
(check all that apply)

- ☐ Home Modifications
- ☐ Purchase or refinance a home
- ☐ Personal attendant
- ☐ Meals and lodging
- ☐ Home health care
- ☐ Housekeeping service
- ☐ Prescriptions
- ☐ Respite care
- ☐ Special equipment/assistive devices
- ☐ Transportation
- ☐ Other _____

• **Housing**
(check all that apply)

- ☐ Home Owner
- ☐ Renter

Landlord _____

Address _____

City/State/Zip _____

Phone _____

- ☐ Nursing home
- ☐ Foster home/adult family home
- ☐ Group home/community residence
- ☐ Living with adult/adult children
- ☐ Homeless
- ☐ Other _____

Type
- ☐ Single family unit
- ☐ Multi-family unit-number of units_____
- ☐ Mobile home
- ☐ Other _____

_____

Assistance received from:
- ☐ League of Human Dignity, Barrier Removal Program
- ☐ Housing and Urban Development, Section 203
- ☐ Making Homes Accessible (MHA)
- ☐ Rural Development, Section 502
- ☐ Rural Development, Section 504
- ☐ Weatherization

• **Personal**
(check all that apply)

Veteran Status
- ☐ Veteran
- ____☐ The person with a disability is a veteran
- ____☐ The spouse of applicant with a disability is a veteran
- ____☐ The parent of applicant with a disability is a veteran
- ☐ Veteran was in military service during a war

• **Personal**
(check all that apply)

Veteran Status (continued)
- ☐ Veteran has a service-connected disability
- ☐ Veteran is a resident of Nebraska

Dates of service _____

United States Citizenship Attestation
For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

☐ **I am a citizen of the United States.**

– OR –

☐ **I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows:** _____

_____.

Are you registered to vote?
☐ Yes ☐ No

Insurance
- ☐ Health Insurance

Specifiy _____
- ☐ Medical Assistance/Medicaid
- ☐ Medicare

Assistance
Check any of the following that have provided assistance to you (i.e. information, referral, or funding) during the last year:
- ☐ Area Agency on Aging
- ☐ Hotline for Disability Services
- ☐ Independent Living Center
- ☐ Nebraska Assistive Technology Partnership
- ☐ Nebraska Commission for the Blind and Visually Impaired
- ☐ Nebraska Commission for the Deaf and Hard of Hearing
  - __☐ Assistive listening devices
  - __☐ Decoder loan
  - __☐ Hearing aid bank
  - __☐ TDD loan
- ☐ Nebraska Assistive Technology Partnership/Education Project
- ☐ Nebraska Health and Human Services
  - __☐ Developmental Disabilities
  - __☐ Disabled Persons and Family Support
  - __☐ Medicaid Waiver
  - __☐ Medically Handicapped Children's Program
  - __☐ Mental health services
  - __☐ Social Services Block Grant
- ☐ Nebraska Veterans' Aid Fund
- ☐ Paralyzed Veterans of America Education Center
- ☐ United Cerebral Palsy of Nebraska
- ☐ Veterans Service Office
- ☐ Vocational Rehabilitation
- ☐ Other _____

• Financial Information

List the amount of income you receive (i.e. your family) from each of the sources below. Single adults (19 years of age or older with no minor children) should list only your income. Families should list income of married couples or income of all adults, including wages of children ages 14-18.

Gross Income (your income before deductions)	**Amount**	**How often received**	**Who receives it**
Wages, overtime, bonuses, commissions, etc.			
Self-employment (use current IRS 1040)			
Interest dividends, money from investments and capital gains			
Social Security Retirement			
Social Security (SSI)			
Social Security Disability			
Veteran's Benefits			
Pensions			
Retirement, Keogh Accounts, IRA's, etc.			
Inheritance, estates, trust funds, etc.			
Aid to Aged, Blind and Disabled (State Supplemental Check)			
Temporary Assistance for Needy Families (TANF)			
Alimony/Child Support			
Compensation (worker's and unemployment)			
Rental income and boarders			
Miscellaneous (insurance settlements, lottery winnings, and other, please describe)			

Assets List assets that are readily available (e.g. cash, checking accounts, stocks, bonds, whole life insurance, certificates of deposit, farmland, etc., and any liquid assets that can be converted to cash without incurring a substantial tax penalty for early withdrawal)	Amount

Expenses related to your disability (e.g. medication, doctor bills, transportation to the doctor, special equipment, etc.)	Amount

• Release/Agreement Form

I verify that the information provided on this application is correct and complete.

I understand that whenever changes occur in the information provided, I need to report them immediately to one of the agency/agencies helping me obtain devices or services.

I understand I have the right to appeal if I am not satisfied with an agency's action.

I understand that this is a **multi-agency form**. The agencies/programs listed below may contact each other to determine my financial eligibility for their programs, and may verify my need for the support for which I have applied. I authorize the release of this information to be used for referrals/services for which it is determined I may be eligible. It is my understanding that this information will be held confidential by all the agencies listed.

- Client Assistance Program
- Hotline for Disability Services
- Independent Living Centers
- Making Homes Accessible (MHA) Program
- Muscular Dystrophy Association
- Nebraska Advocacy Services
- Nebraska Assistive Technology Partnership
- Nebraska Assistive Technology Partnership/Education Project
- Nebraska ChildFind
- Nebraska Commission for the Blind and Visually Impaired
- Nebraska Commission for the Deaf and Hard of Hearing
- Nebraska Department of Health and Human Services
- Nebraska Easter Seal Society
- Nebraska Department of Veterans' Affairs, Nebraska Veterans' Aid Fund
- Nebraska Housing Developers Association and Home Ownership Program
- Paralyzed Veterans of America Education Center
- Rebuilding Together
- Temporary Assistance for Needy Families (TANF)
- The Arc of Nebraska
- United Cerebral Palsy of Nebraska
- US Department of Agriculture (USDA)
- Vocational Rehabilitation
- Other _____

_____

Information may be released and shared on my behalf with the following family members and individuals:

_____

_____

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

_____

Signature of applicant (or guardian) **Date**

The following information is being requested for Federal reporting purposes only. Your response is optional and will not affect your eligibility determination. We would appreciate your assistance by providing a response.

Ethnicity/race (please check)

☐ White (non Hispanic) ☐ Black (non-Hispanic) ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander

☐ Hispanic ☐ Multi-Racial ☐ Other _____

Return this form to: Assistive Technology Partnership
Corinne Holtz, Resource Coordinator
3901 N. 27th Street, Suite 5
Lincoln, NE 68521

If you have questions about this form, call:
Lincoln (402) 471-0734 or
Toll Free (888) 806-6287

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